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Amended July 9, 2012

Notice of Independent Review Decision
Reviewer's Report

DATE OF REVIEW: June 29, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar Epidural Steroid Injection at Bilateral S1 (64483); Additional Level at L5-S1 (64484); Epidurography x 4 (72275); Fluoroscopic Guidance (77003); and Therapeutic/Prophylactic or Diagnostic Injection x 4 (96372).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld	**(Agree)**
[ ] Overturned	(Disagree)
[ ] Partially Overturned	(Agree in part/Disagree in part)

The requested service, Lumbar Epidural Steroid Injection at Bilateral S1 (64483); Additional Level at L5-S1 (64484); Epidurography x 4 (72275); Fluoroscopic Guidance (77003); and Therapeutic/Prophylactic or Diagnostic Injection x 4 (96372), is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
1. Request for a Review by an Independent Review Organization dated 6/5/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 6/14/12.
3. Notice of Assignment of Independent Review Organization dated 6/15/12.
4. Claims Management Inc: Independent Review Organization Summary dated 6/19/12.
5. Hospital Associate Statement dated 10/15/11.
6. Hospital Adult Assessment dated 10/14/11.
7. Hospital Prescription dated 10/14/11.
8. Hospital Acute Care Accident Report dated 10/14/11.

9. testing dated 10/14/11.
10. Hospital chemistry panel dated 10/14/11.
11. Hospital Cumulative Report Reference Lab dated 10/14/11.
12. Hospital Radiology Consultation Report dated 10/14/11.
13. Hospital Imaging report of the lumbar spine dated 10/14/11.
14. Health Services Physical Medicine Evaluation dated 10/19/11.
15. Health Services clinic notes dated 12/13/11, and 10/17/11.
16. Texas Worker's Compensation Work Status Report dated 1/4/12, 12/13/11, 11/21/11, 11/7/11, and 10/14/11.
17. Prescriptions dated 11/7/11, 10/31/11, and 10/17/11.
18. Physical Medicine Modality Flow Sheet dated 10/19/11.
19. Health Services Daily Note dated 11/7/11, 10/28/11, 10/27/11, 10/26/11, 10/21/11, 10/20/11, and 10/19/11.
20. Imaging MRI of the lumbar spine dated 10/31/11.
21. Radiology Report dated 10/31/11.
22. Sports Medicine and Orthopaedic Group – MD dated 5/4/12, 4/25/12, 1/25/12, 1/4/12, 12/14/11, and 11/21/11.
23. Surgery Center Operative Report dated 2/29/12, and 12/5/11.
24. Physician Work Status Report dated 4/19/12.
25. Medicine and Orthopaedic Group Pre-Authorization Request dated 10/14/11.
26. Denial documentation dated 5/22/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reportedly injured her low back on xx/xx/xx when lifting a box. Diagnoses included low back pain, acute lumbar strain, lumbar disc syndrome and lumbar radiculopathy. X-rays showed no lumbar abnormalities. A 10/13/11 lumbar MRI showed a central L5-S1 disc extrusion with flattening of the ventral aspect of the thecal sac with no nerve root displacement identified. Conservative treatment measures included medications, physical therapy, and work restrictions. A lumbar epidural steroid injection (ESI) was performed on 12/5/11 with reported 75% relief which lasted one month. A second ESI was performed on 2/29/12 which provided 50% initial relief and then gradual return of low back pain referred to the lower extremities. A physician record dated 4/25/12 noted the patient had mild discomfort in the bilateral lower paraspinal regions with minimal neural tension findings and mildly restricted motion in flexion and extension. Authorization for repeat ESI and related services has been requested. The URA has denied this request citing a lack of medical necessity.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The requested epidural steroid injection is not supported as medically necessary based on the information provided. Official Disability Guidelines (ODG) indicate that patients must have objective findings of radiculopathy to warrant epidural steroid injection. The records do not indicate either focal radicular symptoms or objective evidence of radiculopathy on exam. Further, the MRI of the lumbar spine from 10/31/11 does not show neurocompressive pathology. Specifically, the study shows no nerve root displacement. Overall, the patient does not meet ODG criteria for the requested epidural steroid injection, and the request cannot be supported as medically necessary.

Therefore, I have determined the requested service, Lumbar Epidural Steroid Injection at Bilateral S1 (64483); Additional Level at L5-S1 (64484); Epidurography x 4 (72275); Fluoroscopic Guidance (77003); and Therapeutic/Prophylactic or Diagnostic Injection x 4 (96372), is not medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)